COMPLETE YOUR FORMS | MEDICAL INFORMATION

Return all documents to Sedgwick in one of three ways:
upload: mySedgwick®| email: WalmartForms@sedgwicksir.com | fax: 859-264-4372 or 859-280-3270

Associate name: John Dallinga **Associate WIN:** 229298296
Case number: 4A2502CWL190001GI

PART B: AMOUNT OF LEAVE NEEDED

5. Will the associate be required to be away from work for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ✓Yes

   If so, provide an estimate of the continuous dates the associate will be away from work:
   Start date: 2|5|25 End date: 5|19|25

6. Will the associate need to attend follow-up treatment appointments because of the associate's medical condition? ___No ✓Yes

   If so, are the treatments medically necessary? ___No ✓Yes

   Estimate the treatment schedule, if any. Include the dates of any scheduled appointments and the time required for each appointment, including any travel time and any recovery period. **Please provide a numerical response** – For example: 1 appointment every 3 months, and requires 1 day of recovery per appointment:

   Frequency: 1-2 appointment(s) every _____ week(s) *or* 3 month(s)

   Duration: 4 hour(s) *or* ___ day(s) per appointment

7. Will the condition cause episodic flare-ups periodically preventing the associate from performing his/her job functions? ____No ✓Yes

   Is it medically necessary for the associate to be absent from work during the flare-ups? ____No ✓ Yes

   If so, explain: If he develops shortness of breath he will be unable to work.

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of time the patient may need to be away over the next 6 months. **Please provide a numerical response** – For example: 1 episode every 3 months lasting 1-2 days:

   Frequency: 1 time(s) per _____ week(s) *or* 2-3 month(s)

   Duration: 8 hour(s) *or* ___ day(s) per episode

8. Will the associate need to work part-time or on a reduced schedule because of the associate's medical condition? ✓No ___Yes

   If so, is the reduced number of hours of work medically necessary? ___No ___Yes

   Estimate the part-time or reduced work schedule the associate needs, if any:

   _____ hour(s) per day; _____ day(s) per week from _____ through _____

ADDITIONAL INFORMATION: Please reference the question number for any related information you provide

_____

_____

R. Uhle 4/9/25

Signature of healthcare provider **Date**

T4A2502CWL190001GI-2048